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the CHILD

TOWARD BETTER CARE FOR RURAL MOTHERS

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THIS IS the story of what one State, Maryland, has been trying to do to improve rural obstetrics. It is presented with the full realization that it is only a small beginning and not a finished product. If, however, anyone finds in this any worthwhile ideas or can give me suggestions and criticisms which will bring about an improved rural maternity program, then the story is worth presenting.

For the purpose of organizing a fairly close-knit maternity program, Maryland is fortunate by virtue of its small size. The State, insofar as health activities are concerned, is divided into two distinct administrative units, namely, the city of Baltimore, under the city health department, and the remaining 23 counties of the State, under the Maryland State Department of Health. Each of these divisions contains approximately half the total population of the State, that is, about one million people each. The story that follows concerns the million who live in the rural areas of Maryland, outside the city of Baltimore, and who are served by the Maryland State Department of Health.

The State health department entered the field of maternity care in Maryland in 1928, establishing at that time a single clinic in one of the counties not far from Baltimore. This clinic was conducted by one of the local physicians, paid on a session basis. Since then the prenatal program has expanded gradually and steadily until at present there are 53 clinics operating throughout the State. During 1946 these 53 clinics held 976 sessions and furnished prenatal care to over 2,600 women. It is important to point out that this expansion has been carried out with the active cooperation and consent of the individual local physicians and the local county medical societies. In no instance has any attempt been made to set up clinics in areas where there was any concentrated opposition to the ideas; and in every instance local physicians have been urged to conduct the clinics for the health department. Again, conditions in Maryland are fortunate in that there has been built up over the years a carefully nurtured good will between practicing physicians and the health department. Without this good will, the program would be impossible.

Six types of workers are involved in the operation of our maternity program: (1) The local practicing physician, (2) the general-staff public-health nurse, (3) the deputy State health officer, or county health officer, (4) the certified nurse-midwives, (5) a public-health-nursing consultant in obstetrics, (6) a physician, who is an obstetric consultant.

Local practitioners in most of the counties have cooperated by agreeing to conduct the prenatal clinics. In this way the local man is made to feel that he is part of the program and not merely looking in from the outside. For such services he is paid $8 for a half-day session and $15 for a full-day session. In 1946, 33 physicians were carried on the health-department pay roll for such services.

It must be admitted that in many instances physicians are simply too busy or are not interested in contributing their time for such small remuneration, but constant efforts are being made to interest new men in taking part in the program. Our hope is eventually to have two or more in each community who will give their time to this project.

The general-staff public-health nurse gives approximately one-quarter of her time to prenatal and maternity work. She usually is the first person outside the family circle to learn that a patient is pregnant. She often knows the patient's individual problems, and she takes an active part in seeing that the patient either reports to the physician of her choice or attends one of the prenatal clinics. From this point on, the general-staff nurse sees the patient, both through home visits and at the clinic, throughout her pregnancy, instructs her concerning her care, and helps her with her plans for delivery and for care of the infant.

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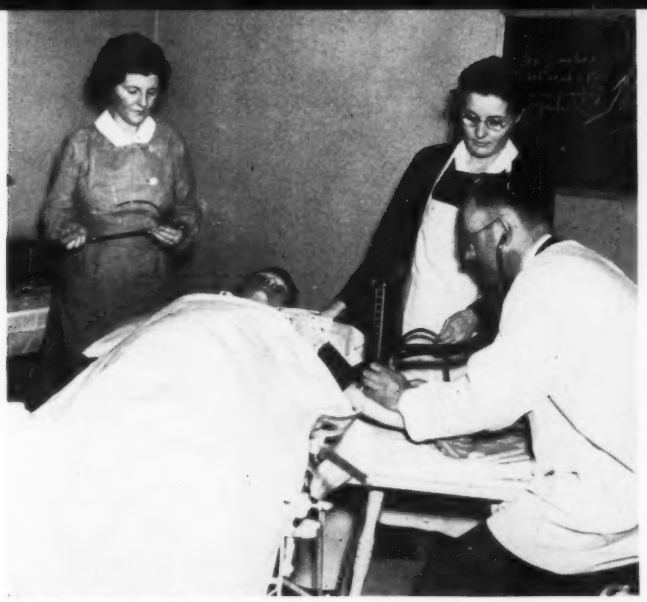
The deputy State health officer has the same function here as elsewhere in the country. He serves as administrative head of the local health-department unit. As such he authorizes and schedules the prenatal clinics, furnishes nursing personnel to conduct them, and arranges, wherever possible, with the local physicians to conduct the clinics. The success or failure of the maternity program in any given county is dependent largely on the interest, initiative, and tact of the individual health officer and his relationship with the local physicians and the local county medical society. In those instances in which local physicians do not conduct the prenatal clinics, the deputy State health officer takes over this function himself and examines and instructs the patients.

When physicians are scarce

The certified nurse-midwives are, of course, graduate nurses who have had specialized postgraduate training in maternity work. They have been assigned to those areas in the State where physicians are most scarce and hospital facilities meager or lacking. At present in Maryland only six are employed, but four or five times that many could be used if they were available.

These nurse-midwives devote their entire time to the maternity program, arranging, attending, and helping with the prenatal clinics, making home visits to prenatal and postpartum patients, carrying out deliveries in the home, and keeping a close eye on the activities of the local "granny midwives." The work of the granny midwives is unfortunately still necessary in many of the more remote areas of the State. In 1945 these untrained midwives performed 7 percent of the total deliveries in the counties.

The nurse-midwife can book for delivery only those women who have been examined and found normal by a physician. When in difficulty, she calls either



Regular medical supervision helps to make her pregnancy safe.

A certified nurse-midwife weighs a baby while the family look on.

the deputy State health officer or one of the local practitioners for advice.

The public-health-nursing consultant in maternity care is likewise a certified nurse-midwife, who operates out of the central health-department office and goes from county to county helping the general staff nurses with their maternity work, advising the nurse-midwives, and instructing and inspecting the granny midwives. She helps in the establishment of clinic routines, home-visit techniques, and all aspects of prenatal, delivery, and postpartum care that relate to nurses, nurse-midwives, and granny midwives. In this capacity she visits, from time to time, all the 23 counties of the State.

The last member of the maternity team is a physician, the obstetric consultant. This position was first created 10 years ago on a part-time basis, but as the work developed, it became apparent that it demanded the full-time services of at least one person. At the present time, there is a single obstetric consultant who is able to devote his entire time to this work without having to take time for private patients of his own. The great disadvantage of employing a man in this capacity on a part-time basis had proved to be the fact that so often he found it necessary to cancel clinic visits at the last minute because of his private practice.

The consultant travels from county to county on a prearranged schedule and visits certain of the prenatal clinics while they are in operation. All clinic patients having abnormalities or suspected of having them are referred to the clinics he attends. His major function in respect to the clinics is, therefore, the examination of abnormal cases and the making of necessary arrangements for their proper care. In this way he comes into contact with the deputy State health officers, the local physicians, the staff public-health nurses, the nurse-midwives, and on occasion, the granny midwives.

Matters of maternity care in general, and those relating to specific patients, are discussed at these clinics. In addition, the consultant renders, when requested, free consultant service to any of the physicians of the State. He remains on 24-hour call for this purpose and sees patients in either the physician's office, the patient's home, or the hospital.

When time and travel permit, he will go to help out with difficult deliveries. He appears before local medical-society groups to give talks on obstetric subjects and holds informal discussion groups. Recently there has been a gratifying move on the part of the rural hospitals to ask his advice in improving their maternity sections, and in one instance, he has been placed on the consultant staff of a local hospital.

Lest you think he must be like a cat with nine lives to be able to accomplish all this, it must be admitted that the demands upon him are not equal to his willingness to help. Free consultation service is a new idea, and like everything else that is free is looked upon with some skepticism of its value. The progress along this line is slow, but is still progress.

An extremely important feature of the obstetric consultant's status is a close working arrangement with a teaching hospital. In addition to his position with the health department, he is likewise on the staff of a teaching hospital in Baltimore. This makes it possible for him to arrange hospitalization in a teaching hospital with a large obstetric service for any patient, regardless of her financial status, who presents any major obstetric abnormality needing specialized care. He can obtain any special form of study or treatment which cannot be gotten locally. His association with a teaching hospital further serves to keep him abreast of current advances in obstetrics. And lastly, it facilitates arrangement of postgraduate courses in obstetrics for rural practitioners. This was done for the first time this year, when a total of 31 physicians attended a 10-day postgraduate course at the two teaching hospitals in Baltimore.

From the patient's point of view, here is a plan that assures that any expectant mother in Maryland, irrespective of her financial status, can obtain modern obstetric care and advice.

Clinic examination includes all the usually accepted basic examinations: Pelvic measurements; blood studies, in-

(*Continued on page 109*)

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CHILDREN'S BUREAU REVIEWS A YEAR'S WORK

This is a condensed and somewhat rearranged version of the thirty-fifth annual report of the Children's Bureau, for the period July 1, 1946, to June 30, 1947. The complete report can be found in the Annual Report of the Federal Security Agency, as part of section 1, which is the report of the Social Security Administration.

BASIC to all the work of the Children's Bureau is its responsibility, under the act of Congress creating the Bureau in 1912, for investigating and reporting "upon all matters pertaining to the welfare of children and child life among all classes of our people."

Little occurs in the economic, social, and cultural life of the Nation that does not in one way or another impinge on the welfare of children and child life. Since the Bureau must work within the limits of its personnel and budget, it must be selective in its investigations and reporting, focusing its efforts on areas where there is most need for information and where information can best be used in helping public and private services increase their usefulness to children.

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Research

The year 1945 was a banner year for the United States in the safeguarding of mothers and children from fatal risks in childbearing and in infancy. The maternal mortality rate, 20.7 deaths for each 10,000 live births, was the lowest ever recorded in this country and 9 percent below the 22.8 recorded for 1944. The infant mortality rate as conventionally computed declined from 39.8 for each 1,000 live births in 1944 to 38.3 in 1945. When adjusted for the changing number of births, the rates were 39.4 in 1944 and 38.2 in 1945, a decline of 3 percent. Preliminary figures for 1946 indicate a further decline.

Despite the encouraging showing in national rates, maternal mortality in some States, particularly among nonwhite mothers, was disproportionately high. Analysis of mortality rates in 1944 indicates that reduction in maternal mortality among nonwhite mothers lags 15 years behind that for the rest of the population.

A study of neonatal deaths emphasized again the importance of concentrating attention on risks in the first month of life if the infant mortality rate is to be lowered significantly in coming years. While death rates for the first year of life dropped 29 percent from 1935 to 1944, rates for the first month declined only 24 percent. Sixty-two percent of all infant deaths in 1944 occurred when the infants were less than a month old. Prematurity is the greatest single cause of infant mortality; at least two-thirds of these deaths from prematurity could be prevented if the infants could receive care in modern "premature centers" with specially trained medical and nursing personnel.

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By June 30, 1947, all States were participating in the study of child-health services undertaken by the American Academy of Pediatrics with the cooperation of the Public Health Service and the Children's Bureau. The Bureau has aided this study, the most comprehensive one of its kind ever undertaken in this country, by lending the director of its Division of Research in Child Development and a research assistant to the executive staff of the study. . . .

Studies to develop plans for dental-health services for children continued during the year. One was an evaluation of a dental-health program for elementary-school children, involving the analysis of dental records collected through the Cleveland Department of Education Dental Health Service. Records of mobile dental units serving children in rural areas in Kentucky were studied to obtain data on cost, coverage, man-hours, types of services, and the time necessary for various operations. A study of the budgets and expenditures for dental-health programs of all State health departments from

1937 through 1946 was started. In June 1947 the Bureau held a conference with authorities on orthodontic needs of children and the methods, services, and problems involved in meeting those needs.

In cooperation with the National League of Nursing Education, the Bureau made a controlled study of the elements that go to make up good pediatric nursing care in hospitals. Results of the study have been published by the National League and so made available to hospitals and others responsible for standards of nursing care of sick children.

A conference was held of representatives from the fields of education, medicine, nursing, medical social work, and welfare, to advise on a study of the various vision-testing procedures commonly used in elementary schools. The study is to be made jointly by the Bureau and the National Society for the Prevention of Blindness, with the cooperation of a State health agency.

The increasing number of children entitled to benefits under various public programs makes timely a study of laws and procedures governing the legal guardianship of children. Many such laws are antiquated, and practices under them have lagged far behind modern knowledge of the social needs of children. The Bureau will soon issue the final report on its study of court records, procedures, and cases of children under guardianship in two local jurisdictions in each of six States.

Advisory services on problems affecting children

Consultation service was given to States and local groups in the field of juvenile delinquency and community planning for children and youth. In addition, the Bureau completed several special studies in that field. The report of the Bureau's 7-year project in St. Paul, Minn., demonstrating the value of integrated community services for children showing early behavior problems, was published under the title, "Children in the Community." . . .

The method of reporting juvenile-court statistics, collected by the Bureau each year since 1927, was revised to attain broader coverage through collection of local data by State agencies, and to yield information both on the types of cases disposed of and on the number of children involved. Final figures for 1945 show a 6-percent increase over 1944 in the number of delinquency cases disposed of by courts reporting to the Children's Bureau in both years.

Much staff time went into preparing material for consideration by the National Conference on Prevention and Control of Juvenile Delinquency, called by the Attorney General.

There have been reports of inadequate, if not positively bad, care and treatment of boys and girls in training schools in many States, because of poorly qualified personnel and inadequate facilities. Several State schools were visited, and suggestions were given on improving standards of service and integrating State training-school programs into State child-welfare programs. At the request of the Child Welfare Division of the American Legion, a study was made of the policies and practices of 22 States in admitting pregnant feeble-minded and epileptic girls to State training schools.

In connection with the wide variety of requests that come to the Bureau for information and counsel on problems connected with the care of children away from their homes, considerable exploratory work was done during the year in collating facts about current and desirable practices on such aspects of foster care as foster-home finding, intake policies, size of case loads, board rates, costs of institutional care, personnel practices, in-service training programs, foster-parent education, licensing, and general standards of care. Special attention was given to problems of interstate placement.

Agencies seek help

It becomes increasingly evident that the public is looking to public welfare agencies for guidance and assistance in adoption matters. These agencies, in turn, look to the Children's Bureau for counsel in the development of their policies. Advice on adoption policies was given also to private agencies. The Bureau's consultant on adoptions worked with the March of Time on its

What the Social Security Administration recommends on Children's Bureau programs

Legislation and appropriations providing for the progressive development of State-wide programs at a rate consistent with availability of personnel and with facilities that meet standards established under State plans, for the purpose of assuring that child health and welfare services will be available as needed for all children in all political subdivisions of each State. Provision of such services without discrimination as to race, creed, nationality, residence, citizenship, or economic status.

Development within the health and welfare programs of measures necessary to assure that children in migrant families will receive the services they need.

Priority of attention to development of programs of health, medical, and dental services for children of school age.

Safeguarding the rights of parents and children to such services by requiring that State plans provide an opportunity for fair hearing before the State agency responsible for the program, whenever a claim for care or services under the plan is denied; and adequate restrictions on the use or disclosure of information concerning persons applying for or receiving such services to purposes directly connected with the administration of such services.

Special provision of financial aid in training of professional and technical personnel needed in making child health and welfare services available throughout the country.

Effective coordination of the health and welfare services for children with other health and welfare services.

Administration of the maternal and child health and crippled children's services by the same State health agency in each State by the end of a 5-year period.

Appointment by each State agency administering maternal and child health and crippled children's services of a general advisory council providing adequate representation of the public as well as of the professions.

More adequate financial implementation of the basic act of 1912 creating the U. S. Children's Bureau, to enable that Bureau to strengthen and broaden its work as a center of information related to children; to evaluate current research in the physical, biological, and social sciences that pertain to the growth and development, the health and well-being of children and young people; to assist in financing specific research projects by competent research authorities to fill in recognized gaps in these fields of research; and to undertake research and investigations that deal with the child as a whole or with specific problems that require Nation-wide study or that have Nation-wide significance to State and community health and welfare programs for children or mothers.

special feature, "Nobody's Children." The Bureau's folder on adoption was reissued under the title, "When You Adopt a Child."

There is a continuing need for day-care services for children, but the supply is diminishing. Requests for counsel received from Federal, State, and local agencies by the Bureau covered problems of licensing, standards, building requirements and equipment, and methods of appraising need for programs. An interpretation of foster-family day care was published under the title, "Mothers for a Day."

Interest in improving services to unmarried mothers and their babies has become Nation-wide. The Bureau was called into consultation by public and private agencies in several States. Improvements were reported during the year in methods of birth registration as one means of safeguarding the welfare of children, particularly those born out of wedlock.

The Bureau's advice on homemaker service has been sought by both private and public welfare agencies, which are making more use of homemaker services to give trained and supervised care for children in their own homes.

Increasingly, agencies are recognizing the therapeutic value of group work, as distinct from individual case-work, with children. The Bureau advised several States on the use of group work in convalescent-care programs and camping programs for children with physical handicaps.

For migratory workers' children

Evidence of the health and welfare needs of children of migratory workers, among the most neglected in the Nation, was presented by the Bureau at meetings of the Federal Interagency Committee on Migrant Labor, of which the Children's Bureau is a member. In recommending that all appropriate State and Federal agencies carry through practical measures "which will insure adequate housing, health, nutrition, welfare, and related services," the committee made suggestions on how conditions for children might be improved.

Advice on services for children in minority groups was given by the Bureau to several national organizations, public welfare agencies, and private child-caring agencies.

"When You Adopt a Child" is the title of a Children's Bureau folder that endeavors to answer some of the questions raised by persons who are thinking of adopting a child.

Great increases in college enrollments of married students with families have created problems for public health and welfare agencies. At the request of the American Council on Education, the Bureau cooperated in a survey of community services needed for the care of these families.

To meet the growing volume of requests for guidance in the use of psychological and psychiatric services by public health and welfare agencies in all programs of foster-family and institutional care of children, the Bureau conducted a number of field investigations during the year. Visits were made to public and private agencies in several States to observe services for children with disturbed behavior.

On behalf of the Interagency Committee on Youth Employment and Education, the Chief of the Children's Bureau, who was chairman of the committee, late in 1946 submitted a report and recommendations to the Director of War Mobilization and Reconversion. The report summarizes the observations of 11 Federal agencies on problems of school and employment opportunities for young people and lack of community preparation to deal with youth's needs in the postwar period.

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Reporting services

Information about the research findings mentioned here and about other studies now under way is available on request from the Bureau. Results of the Bureau's studies and surveys are communicated to public and private agencies administering programs for children. In its monthly periodical, *The Child*, and through other mediums, the Bureau discharges its responsibility of reporting to the public and to professional workers on all aspects of child life.

In the fiscal year 1947, 234,000 letters came to the Children's Bureau. Many could be answered with a publication; others needed, and got, the personal attention of the Bureau's experts.

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During the fiscal year 2,100,000 publications were sent out in response to requests. The great majority were the Bureau's well-known bulletins for parents. More than a million copies of "Infant Care" were requested from the Bureau, and another 397,000 were sold by the Superintendent of Documents. From 1914, when the first edition of this bulletin was brought out, to the end of June 1947, more than 20½ million copies had been distributed. Requests during the year for free copies of "Prenatal Care" totaled 232,100 and for "Your Child From One to Six," 237,000. The Bureau issued 35 new and 14 revised publications.

As one way to report to the people what it knows and to learn from the people what they want from public service, the Bureau has always kept in close

touch with the many National, State, and local groups concerned with the welfare of children. During the war, leaders from many of these groups formed a national body, known as the National Commission on Children in Wartime. This organization was immensely valuable in counseling the Bureau and in focusing public attention on the needs of children under war pressures. In December 1946 the Commission reconstituted itself as the National Commission on Children and Youth and voted to continue as a body advisory to Federal agencies and to citizen groups supporting programs for children and youth. Members are appointed, on advice of the Executive Committee, by the Commission's chairman and by the Chief of the Bureau.

At its first meeting in December the new Commission adopted an "Action Program for 1947 and 1948." This action program emphasized again the need for expansion of social-security programs affecting family income; child-welfare and child-health services; Federal and State aid for education; mental-health and guidance programs; recreational opportunities for children; improved child-labor legislation and employment opportunities for boys and girls ready to start work; State and community planning for children and youth, with youth participation in the planning; and international action to strengthen services for children and youth in all countries. The Commission strongly recommended that a 1950 White House Conference on Children be held and that in anticipation States and local communities measure the progress made since the last conference and, on that basis, determine problems that need to be taken up at the 1950 conference.

Grants-in-aid programs

The three programs for maternal and child welfare under the Social Security Act are substantial expressions of the principle that only through the sharing of responsibility by Federal, State, and local governments can the Nation's children be assured of their right to a good start and a fair chance in life.

Title V of the Social Security Act authorizes annual appropriations for grants to the States to improve and extend their health and welfare services for mothers and children. Under the amendments of 1946 these grants are $11,000,000 for maternal and child health services, $7,500,000 for services for crippled children, and $3,500,000 for child-welfare services. All 48 States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands receive grants for all three programs. The Virgin Islands were brought under coverage of the act, as of January 1, 1947. The 1946 amendments marked the second time that grants had been increased. In 1935, when the act was passed, they totaled $8,150,000. That sum was stepped up to $11,200,000 in 1939 and to $22,000,000 in 1946.

Unlike the insurance and public-assistance programs under the Social Security Act, which are designed to *strengthen a family's economic security* by furnishing a basic minimum income when earnings are interrupted, the grants-in-aid programs administered by the Children's Bureau are intended to promote and *improve the family's general welfare* through providing public health and welfare services. None of the Federal money under these programs is paid directly to any parent or child. It goes to State agencies to strengthen, extend, and improve the work of these agencies and their counterparts in local communities. . . .

To develop standards of good service, to meet requests from States for advice in the development of their programs, and to work on the many problems involved in reaching children needing care, the headquarters staff of the Children's Bureau includes a wide range of professionally trained people—obstetricians, pediatricians, medical social workers, nurses, nutritionists; a psychiatrist and a psychologist; a dentist, a physical therapist, a hospital-administration consultant; and social workers with special training and experience in child-welfare services, in public welfare administration, in group work, and in foster-home and institutional care of children. In most of the Social Security Administration regions the Bureau has teams of regional workers whom the State agencies can consult about their federally aided programs. Owing to inadequate funds, some regional staffs are incomplete. Advisory committees in various technical fields assist the Children's Bureau in developing policies relating to the administration of grants in aid. . . .

Immediately after increased funds were appropriated by Congress in August 1946, the Bureau called together its advisory committees to make recommendations on how the States might best improve their health services for mothers and children. The State and Territorial Health Officers' Association was another source of guidance in developing these Federal-State programs. It was agreed that increased effort should be put into (1) extending or developing new programs for children with rheumatic fever, cerebral palsy, hearing defects, and other crippling conditions; (2) demonstrating school health service projects in selected areas; (3) increasing development of maternity-care programs; (4) increasing and improving facilities for care of prematurely born infants; (5) developing medical and dental care programs for children; and (6) promoting mental-hygiene programs for children.

Maternal and child-health services

In all States, maternal and child-health programs are administered by State departments of health, through divisions or bureaus of maternal and child health. In 40 States, such divisions are directly under the State health officer. Other States vary in their administrative organization.

The function of the State division or unit is to develop and provide, with the help of local health departments, Statewide health services for children from birth through school age, and for mothers before and after childbirth. The staff may include obstetricians, pediatricians, psychiatrists, psychologists, dentists, nutritionists, public-health nurses, medical social workers, and health educators; a physician is in charge. Through financing postgraduate education and through consultation, the division helps professional workers in private practice or public service to improve the care they give mothers and children.

Services provided by local health departments are primarily for the promotion of health and the prevention of illness. Many health departments also furnish medical, dental, nursing, and hospital care to a limited number of

mothers and children, in special circumstances or in particular areas.

Notable progress was made during the year in extending the range and increasing the coverage of maternal and child-health services. Services traditionally thought of in connection with an essentially preventive and health-promotion program, such as prenatal clinics, well-child conferences, and public-health-nursing services, were increased.

Personnel strengthened

Thanks in large part to the additional funds, there was a general strengthening of medical and other personnel in the State programs. Medical positions in the fiscal year 1947 totaled 185, as against 130 in 1939. Most of the States, with the approval of the Children's Bureau, gave high priority in their budgets to graduate training for their staffs. In 1946–47, State agencies planned to spend approximately $1,000,000 of their total maternal and child health funds on professional training. In the development of in-service training programs, the granting of educational leave, and the planning of training courses for physicians, psychiatrists, psychologists, dentists, nurses, and medical social workers and psychiatric social workers, the Bureau has collaborated closely with the States.

Institutes for nurses in pediatric and obstetric instruction were held in various States during the fiscal year. The Bureau's orthopedic, physical-therapy, and regional nursing consultants participated in an orthopedic workshop conducted by Colorado for public-health nurses. Substantial grants, approved by the Bureau, were made by State agencies to a number of universities for clinical courses in obstetric and pediatric nursing. In May 1947 a maternity-nursing workshop was held under the sponsorship of the Maternity Center Association and the Bureau.

In the field of medical social work, educational and training activities have included consultation with schools of social work in the development of courses in the social aspects of public health and medical care. The Bureau also assisted in developing institutes and seminars for medical-social-work consultants in programs for maternal and child health and for crippled children, held under the sponsorship of various universities.

Six States provided educational leave and stipends for 11 nutritionists for graduate study. The Bureau advised schools of public health and colleges of home economics on their graduate courses of training for nutrition work in the public-health field.

In spite of new staff appointments and the efforts made by the States to recruit professional workers many staff vacancies still existed in many States at the close of the fiscal year 1947. Low salary scales for some public-health positions make recruitment of qualified workers difficult. In all States, shortages of physicians trained or experienced in public health, obstetrics, or pediatrics handicap the development of maternal and child health programs.

On January 1, 1947, at least 2,489 vacancies existed in public-health-nursing positions for which budgetary provision had been made, though 750 more public-health nurses were employed than a year earlier. Of the approximately 150 positions for nutritionists included in the annual budgets of the States, about 1 in every 4 was unfilled. The supply of medical social workers is still limited for the 144 positions budgeted in the maternal and child health programs.

The number of mothers who received antepartum medical services increased from 117,000 in 1945 to 129,000 in 1946, but the number receiving antepartum public-health-nursing services decreased from 238,000 to 231,000. Approximately 31,000 women were given postpartum medical examinations in 1946, as compared with 35,500 in 1945; some 203,000 received postpartum nursing services in 1945, compared with 201,400 in the previous year.

About 456,000 infants and preschool children attended well-child conferences in 1946, as against 426,000 children in 1945. Public-health-nursing services reached about 952,000 infants and preschool children, somewhat fewer than in 1945.

Physicians' examinations of school children numbered 1,587,000, as compared with 1,117,000 in 1945. The number of public-health-nursing visits for school health supervision increased from 2,166,000 to 2,184,000.

Nearly twice as many immunizations for smallpox were given—2,457,000 in contrast to 1,273,000 in 1945. Diphtheria immunizations increased from 1,360,000 to 1,452,000.

Dental inspections of school and preschool children by dentists or hygienists showed a substantial gain in volume in 1946, when they totaled 1,143,000 as compared with 788,000 in 1945.

The foregoing figures, on services for the calendar year 1946, cover the first half of the fiscal year 1947. Since the increased Federal grants did not become available until the fall of 1946, the figures do not reflect fully the gains made possible with the increased appropriations.

Crippled children's services

All States have legislation authorizing an official State agency to provide treatment of and care for crippled chil-

More school-age children were immunized against diphtheria in 1946 than in 1945.

dren. In 31 States, the agency is the State health department; in 10 it is the department of public welfare; in the remaining 12 jurisdictions other agencies are used. In its consultations with State agencies, the Children's Bureau, though recognizing the right of the States to work out their own machinery, has stressed the advantage of unified administration of the programs for maternal and child health and crippled children.

Through their crippled children's agencies, States seek to provide services that include locating all crippled children; diagnosing their crippling conditions; maintaining a register of all crippled children in the State; providing or locating skilled care for crippled children in hospitals, in convalescent and foster homes, and in their own homes; and cooperating with agencies and professional groups concerned with the care and training of crippled children.

Services are State-wide but because of limited funds relatively few States are able to care for all the crippled children within their borders. Nevertheless, with enlarged Federal grants, definite progress is being made in getting more services to more children.

At the close of the calendar year 1946 State registers of crippled children included the names of more than 442,000 children, an increase since December 1945 of about 38,000. A child is eligible for registration if he has a type of crippling for which, according to the approved State plan, children may be accepted for care by the official State agency, and if the crippling condition has been diagnosed by a licensed physician. A beginning was made during the year, with the assistance of the Bureau's Advisory Committee on Crippled Children's Statistics, on a review of the purposes and uses of the crippled children's registers.

Reports by State agencies show increases in the calendar year 1946 in the volume of all types of services. More than 108,000 children received diagnostic or treatment service at crippled children's clinics, as compared with about 93,000 in 1945. More than 27,000 children received hospital care, and 4,700 received care in convalescent homes. Approximately 1,300,000 days of care were provided in hospitals, and 478,000 days in convalescent homes.

Trained homemakers are employed more and more by both public and private agencies to care for children in their own homes while the mother is ill or is absent from the home.

The kinds of services also have been added to. During the fiscal year, Arizona and Hawaii initiated special programs for children suffering from rheumatic fever and rheumatic heart disease, bringing to 22 the number of States operating rheumatic-fever programs. Most of these programs have included complete care, including medical, nursing, and medical-social-work services; diagnostic and treatment services; care in hospitals, sanatoriums, or convalescent homes; and aftercare to safeguard medical gains and help the child's adjustment.

Polio victims numerous

Of all crippling conditions represented on State registers of crippled children, poliomyelitis ranks first. In the calendar year 1946, more than 25,000 cases of acute poliomyelitis were reported, as compared with 13,500 in the preceding year. States in the North Central region, the Rocky Mountain area, and the Far West experienced the highest incidence of the disease.

State directors of programs for crippled children are showing increasing interest in services to children with cerebral palsy. This group of children has consistently ranked second to those with poliomyelitis on State registers. At the present time more than 40,000 such children, nearly 10 percent of the total number on the registers, are known. Since 1937, at least 6 States have carried on special programs for children with cerebral palsy. At the end of the fiscal year 1947, 12 States had special programs for these children, and 7 more were planning such services for the coming year.

Among groups of parents and influential lay organizations, there is a rising tide of interest in cerebral palsy. The National Society for Crippled Children and Adults has recognized the value of this spontaneous lay interest and has organized advisory councils and other services to provide national leadership.

The Children's Bureau, in March 1947, called together a conference of medical specialists and professional persons from related fields concerned with the care of the child with cerebral palsy. This conference, the first of its kind, drew up recommendations to be used as guides by the Children's Bureau and by State crippled children's agencies in getting work started in behalf of these neglected children.

One additional State in 1946 extended its services for crippled children to provide care and treatment of children with hearing defects; 5 States now have such programs. About 20 States make some provision for surgical correction of visual impairments.

Demonstration projects financed with Federal funds in the fiscal year 1947 are making progress. Maryland provided

surgical treatment for children with heart disease. The District of Columbia started general pediatric care for children who were chronically ill. Maine established a special plastic-surgery program. The Alaska Territorial Health Department put into operation the first hospital for crippled children in the Territory, eliminating the need to send all such children to Seattle for hospital care.

Many of our children are fortunate enough to enjoy facilities for recreation like these.

Child-welfare services

In every community there are children in trouble. The trouble may be caused by parents' illness, death, inadequacy, ignorance, or neglect. It may be due to lack of good community resources and safeguards for all children. It may trace back to other factors detrimental to the development of emotional security and good social relations.

These children may be living in their own homes, in foster homes, or in institutions. They may be children of illegitimate birth, or children needing legal protection of their person or property. Their need for help may be reported by parents, other relatives, neighbors, teachers, police, judges, or other community workers.

These are the children for whom the welfare agency of each State has created special child-welfare services. These services are provided usually by a local welfare department under the general supervision of a child-welfare division of the State department of public welfare. Child-welfare staffs of local and State welfare departments include professional social workers with training and experience in the problems of children in need of special care and service.

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Child-welfare services provided in communities can be described best by listing the types of service given in various localities. These services, which all require the skills of qualified social workers, are (1) counseling on problems of children in or out of their own homes; (2) arranging for foster-home or institutional care for children who need care away from their own homes, either temporarily or permanently; (3) finding and securing the necessary attention for children who have physical, mental, and emotional handicaps and who are not receiving the care they need; (4) safeguarding children of illegitimate birth; (5) assisting courts handling children's cases; (6) cooperating with State institutions caring for children; (7) working with mental-hygiene clinics; and (8) assisting schools in handling attendance and conduct problems. Child-welfare workers also help organize community services for children, including services for the prevention of juvenile delinquency.

Soon after Congress made available the increased grants, four regional conferences with State public welfare administrators and directors of child welfare were held to discuss directions the expanded programs might take.

Local, State, Federal resources

At these conferences there was general agreement that the States have a responsibility for seeing that services are provided for all children, irrespective of sex, race, creed, residence, or economic status. Strong evidence was presented that local welfare agencies cannot provide adequate care and facilities without State aid, and that Federal funds are needed to strengthen State resources. An acute shortage of qualified workers is one of the most serious problems confronting all social agencies.

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The full time of a special consultant on the Children's Bureau staff is devoted to advising the States on staff development, methods of training, policies of educational leave, cooperation with schools of social work, and recruiting problems. A Nation-wide survey has been made of the recruiting methods used by State welfare agencies, and an appraisal of the relative merits of such methods is being prepared for the use of these agencies. A subcommittee of the special committee on training and personnel, advisory to the Children's Bureau and the Bureau of Public Assistance, was of major assistance in formulating policies on educational leave and field-work placements.

The regulation which prohibited the use of Federal funds by the States in paying for the maintenance of children in foster care except in certain emergency situations was revised during the fiscal year to allow these funds to be used for the temporary care of children in boarding homes or care in such homes for special groups of children with particular needs.

Services increase

Approximately 230,000 children were receiving noninstitutional services from public child-welfare agencies on December 31, 1946, an increase of about 5 percent over the number a year earlier. Of every 5 children receiving such services, 2 were living with parents or other relatives, 2 were in foster-family homes, and 1 was in an institution or elsewhere.

As of June 30, 1946, there were slightly more than 2,200 full-time child-welfare workers paid from public funds. In addition, 663 other employees were devoting full time, and

Other children seek recreation wherever they can find it, often in undesirable places.

2,981 part time, to child-welfare programs.

Emergency maternity and infant care program

Unlike the regular maternal and child welfare programs under the Social Security Act, which require State financial participation, the special wartime program for emergency maternity and infant care has been financed entirely by the Federal Government from its general tax revenues. Liquidation of the program started on July 1, 1947.

Launched by unanimous vote of Congress on March 18, 1943, the emergency maternity and infant care program has proved to be the biggest public maternity-care program ever undertaken in this country. The Children's Bureau has been responsible for its Federal operations.

Under the program, the Federal Government undertook to provide maternity care for wives of enlisted men in the lowest four pay grades of the armed forces and of aviation cadets, and to provide medical, nursing, and hospital care for their infants during the first year of life. Care provided was without cost to the serviceman's family.

From the start of the program through June 30, 1947, a net total of $124,900,000 had been allotted to the States to cover the cost of care and State administrative expenses. More than 1,420,000 cases had been completed or approved for care.

State health departments administered this program, and to them large credit must go for the efficient operation of the huge undertaking. The many private physicians and hospitals providing care also merit the Nation's gratitude, for without their skills and service the program could not have been carried out. At its peak in 1945, 48,000 physicians and 5,000 hospitals were cooperating. These figures represented 50 percent of all active physicians in private practice at that time, and 90 percent of the registered hospitals other than those caring for mental, nervous, and tubercular patients.

With the close of hostilities in 1945 and the end of Selective Service in March 1947, the need for an emergency maternity and infant care program lessened. Only 152,000 new cases were authorized in the fiscal year 1947, of which 100,000 were maternity cases and 52,000 were infant cases. The year before, approximately 385,000 new cases had been authorized, while in the fiscal year 1945 the number authorized was about 484,000. In the last 6 months of the fiscal year 1947 the number of infant cases represented 41 percent of all authorizations, as compared with 11 percent in July–December 1944. At the close of the fiscal year the States were carrying about 106,000 uncompleted cases.

In liquidating the program, all cases authorized before July 1, 1947, will be completed. New cases may be accepted thereafter only if they were otherwise eligible for care as of June 30, 1947. It is anticipated that care for the last case will be completed within the 2 years between July 1, 1947, and June 30, 1949. Congress has appropriated $3,000,000 for that period.

International cooperation

Together with 21 other Government departments and agencies, the Children's Bureau is cooperating in the program of the Interdepartmental Committee on Scientific and Cultural Cooperation under two acts of Congress relating to international cooperation. Member agencies of this Committee receive a special budget from the Department of State for their activities under these provisions.

Under this program of international cooperation, the Children's Bureau lends other American Republics, on request, the services of its consultants in child health and child welfare for limited periods. It also assists specialists from other American Republics in planning and carrying out studies and observations of child health and welfare services in this country.

During the fiscal year 1947 the Bureau assigned a medical consultant, a nutrition specialist, nurse-midwives, and child-welfare workers to work with government agencies in Argentina, Brazil, Colombia, Costa Rica, Ecuador, Guatemala, Mexico, Panama, and Peru. In some instances this staff gave advisory service in the maternal and child-welfare programs of these countries; in others they helped governments develop training programs for professional workers. . . .

Four specialists from Bolivia, Mexico, Panama, and Paraguay received grants to study child health and welfare services in the United States in the fiscal year 1947. Their schedules in this country were worked out by the Children's Bureau. Similar guidance was given to more than 200 visiting specialists from countries in other parts of the world who were referred to the Children's Bureau by the U. S. Department of State, United Nations agencies, and individual foreign agencies.

Child-health and social problems in border communities were studied at two conferences held in Laredo, Tex., and San Diego, Calif., in May and June

1947, respectively, under auspices of the Mexico-United States Border Health Association. Children's Bureau representatives attended.

The Chief of the Children's Bureau, who is the official United States representative on the council of the American International Institute for the Protection of Childhood, was represented at its meeting in Montevideo, Uruguay, in April 1947. Plans were made at this meeting for the Ninth Pan American Child Congress, to be held in Caracas, Venezuela in January 1948.

To appraise maternal and child welware needs in the Philippines, the Bureau sent a medical consultant and a psychiatrist to the Islands for several months to make observations in cooperation with agencies of the Philippine Government.

Assistance was given the United States Committee for the Care of European Children, responsible for placing unaccompanied children who enter the United States under authorization of the President's directive of December 22, 1945. These placements are made under the supervision of social agencies designated by the Children's Bureau.

Various conferences were held on problems arising from the presence of United States troops in other countries. These relate to questions of paternity, claims for support, and petitions for adoption of children who were born out of wedlock and whose alleged fathers were members of the United States armed forces.

The Chief of the Bureau was appointed to serve as alternate to the United States representative on the Temporary Social Welfare Committee of the Social Commission of the Economic and Social Welfare Council of the United Nations. The Bureau's chief was also appointed as United States representative on the Executive Board of the International Children's Emergency Fund, established to assist in the rehabilitation of children of war-torn countries and for child-health purposes generally. The Associate Chief of the Bureau was appointed Chief Medical Consultant for the International Children's Emergency Fund of the United Nations and visited a number of European countries in connection with planning the program. The Associate Chief also was vice chairman of the United States Delegation to the International Health Conference, which formulated the constitution of the World Health Organization.

A look ahead

From looking backward at the record of achievements, we must turn to look forward at the job still to be done for the children of the Nation.

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Much of the evidence of need for services was presented to the Seventy-ninth Congress, which increased the Federal grants to $22,000,000. Additional testimony was presented to the Eightieth Congress in hearings on the National Health bill, the National Health Insurance and Public Health bill, and the National School Health Services bill.

Further documentation of the need of great numbers of children for a better chance in life was strikingly presented in "A Program for National Security", the report of the President's Advisory Commission on Universal Training, submitted on May 29, 1947.

"The factors that make an individual fit or unfit to defend his country," the report states, "are many years in the making; when an emergency comes, relatively little can be done to remedy his past lacks and present deficiencies." After an illuminating summary of some of the available information on how far we have "actually come in making sure that every child has what all children need," the report concludes that "the children that represent the majority of our future citizens—country children, children in low-income families, and children in minority groups—have a disproportionately small share in resources, safeguards, and opportunities that all children need. Now, as in the past, our cities and industries look to rural areas and low-income groups for population growth, for the development of production, for markets. The handicaps that many American children face in health, nutrition, education, and housing, and the inadequacies in community services and safeguards for children must concern the whole Nation."

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There are some 3,100 counties or equivalent jurisdictions in the United States. Two out of five do not have the service of a full-time public-health unit; one out of three has no public-health nurse. Three out of five rural counties have no regular maternity clinics; two out of three have no well-child conferences. Twenty-five States have no child-guidance clinics in any community. Approximately five-sixths of all the counties have no full-time child-welfare worker paid from public funds. Present workers are most unevenly distributed among the States, and between rural and urban areas. In no State or city of the country is there complete coverage by well-rounded, well-developed programs of child-welfare services.

Research is the cornerstone of an efficient program of services for children. Compared with the widespread research, publicly financed, into the development of plant and animal life, relatively little is done in the field of child growth and development. Many research projects that could be carried out best on a national scale cannot be undertaken because of lack of funds. Many that could be undertaken by public and private agencies in the States and communities also are blocked by insufficient support. Better coordination and interchange of information is needed to multiply the usefulness of the research now going on.

1950 White House Conference

It has become a tradition in the United States every 10 years to assess the condition of children and to measure the distance we have come in providing them with opportunities for wholesome growth and development. This has been the function of the White House Conferences on children. The first was held in 1909; the fourth, in 1940. It is time, now, to plan for a 1950 White House Conference.

Just as we have learned that the welfare of a few children in a community cannot be assured unless all children in the community have the same assurance, so it is with the children of this Nation and of other nations. There must be increasing opportunities for cooperation in matters of concern to children, both between individual governments and through international channels, particularly the United Nations and its special agencies.

Reprints available in about 5 weeks

Care for Rural Mothers

(Continued from page 99)

cluding Rh typing and antibody titering, if indicated; chest plates; and X-ray pelvimetry where indicated. Each patient, whether a patient at a clinic or of one of the local physicians, falls into one of three groups, and her further care largely depends on which group she is in. She is either entirely normal, or presents borderline abnormalities, or presents one or more major abnormalities.

If pregnancy is, and remains, normal the patient will receive delivery care in one of four ways, depending on her own desires and the local facilities available. She may choose her physician for home delivery, provided that the physician will accept her for this; or she may choose her physician for hospital delivery; or she may be enrolled on the home-delivery service of the certified nurse-midwife, in the areas where they are present; or she may engage one of the granny midwives to deliver her at home. This last type of care, of course, is the least desirable.

In those cases presenting borderline abnormalities, such as mild degrees of contracted pelvis, borderline chronic hypertension, and so forth, the patient is seen and evaluated by the obstetric consultant. Together with the deputy State health officer, nurses, and the local physician he takes steps to arrange for the patient's proper care locally. This usually means hospital delivery under the supervision of one of the local physicians, who, in turn, knows he can call upon the consultant for aid and advice if things do not progress satisfactorily.

It is among the patients having major obstetric complications that the greatest good can be done. Those are the patients who will get into serious difficulty unless they receive expert obstetric care. They are likewise seen by the consultant, who verifies, to the best of his ability, the existence of major deviations from the normal.

If the patient lives in an area near one of the better-equipped local hospitals where there is a physician qualified to deal with major abnormalities, the consultant works out with this physician a plan of therapy for the patient. In those areas where there are no adequate hospital facilities or adequately trained physicians, the consultant refers the patient to a Baltimore hospital for further obstetric care.

During 1946, 140 patients presenting major complications of pregnancy were referred to one of the teaching hospitals in Baltimore from the counties of Maryland. Of this number no mothers were lost and only two infants. These patients were made up of those with previous Cesarean section, severe pre-eclampsia, eclampsia, extreme degrees of contracted pelvis, heart disease, and the like, and it is easy to imagine what the outcome might have been had they been in the hands of a granny midwife or a physician with meager obstetric training.

Lest I have given the erroneous impression that Maryland has completely solved the problem of furnishing adequate maternity care to all its mothers, it must be admitted that such is by no means the case. We feel that we have set up a workable scheme to insure that every pregnant woman in the State can, if she and her physician desire it, obtain proper care, but to date these facilities are being used by only a very small percentage of those who need specialized care.

The reasons for this are not difficult to discover. First of all, the patients themselves often do not cooperate, failing to secure medical attention until they are in serious difficulty. Private patients are sometimes reluctant to avail themselves of the free services of the health department. In many instances the physician does not wish, for one reason or another, to take advantage of what is available. Some physicians are definitely opposed to the health-department activities and feel that these are an unwanted entrance into their private domain. Others consider themselves quite capable of dealing with difficult obstetric problems and resent any implication that they need help. And so, although the machinery for furnishing good care exists, it can be said quite frankly that to date it is being used sparingly by the local physicians for their private patients. The clinic patients, however, derive the full benefit whenever they are willing to cooperate.

In spite of the obstacles noted, progress is being made. The time is rapidly approaching when one or more additional full-time obstetric consultants will be necessary to handle the increasing volume of work. The fact that one person has been able to carry the load thus far is proof of the meager use of his services, but the load is becoming heavier as the months go by.

In summary, then, Maryland has over the past 19 years gradually evolved a maternity program which today makes it possible for every pregnant woman in the State to receive adequate obstetric care, irrespective of her financial status, color, or creed. Utilizing a full-time staff composed of general-staff nurses, deputy State health officers in every county, certified nurse-midwives when obtainable, a public-health-nursing consultant in obstetrics, and a full-time obstetric consultant, it is possible to provide expert care to all. Every effort is made to obtain the cooperation of local physicians and to cooperate with them. A close association with a teaching hospital in Baltimore provides facilities for specialized care not available in rural areas.

Until such time as something better comes along, we plan to enlarge along the present lines. To bring the plan to success will require constant education of patients to avail themselves of existing facilities, and equally constant education of the practicing rural physicians.

Reprints available in about 5 weeks

• CALENDAR

Jan. 26–27 — Annual meeting — National Conference on Social Welfare Needs. National Social Welfare Assembly, Washington, D. C.

Jan. 28–30, 1948—National Commission on Children and Youth. Washington, D. C.

Feb. 4—National Social Hygiene Day. Further information from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Feb. 6–7—National Conference on Rural Health, American Medical Association. Chicago, Ill.

Feb. 8—Negro History Week. Association for the Study of Negro Life and History, Inc., 1538 Ninth Street NW., Washington 1, D. C.

Feb. 26—National Committee for Parent Education. Atlantic City, N. J.

NORWEGIAN SCHOOLS OFFER HEALTH SERVICES TO CHILDREN

ANNA KALET SMITH *International Cooperation Service, U. S. Children's Bureau*

HALF A CENTURY has passed since the first physicians were employed in the city schools of Norway. Introduction of physicians in the rural districts has been retarded by the sparsity of Norway's 3-million population, which makes it necessary for school physicians to cope with difficult transportation over long distances.

The urgent need for better health work has been widely recognized, however, and in 1935 and 1936 laws were enacted requiring employment of physicians in all city elementary and secondary schools, and in rural schools whenever the money was available.

Physical examinations

In consequence, the director of school health in Oslo was able to report early in 1947 that children were regularly examined by physicians in all schools of the country, but the extent of the health work varied with the size of the school and other circumstances. In some places the examinations are limited to children entering school, those for whom reexamination was recommended by the school physician at the time of the first examination, and those referred to the school physician by the teacher because of illness.

The school health services in Oslo are typical of those offered in the larger cities. Each child receives a thorough physical examination at the beginning and the end of the school year and oftener when necessary. The physician examines children who have been absent a week or more on account of illness and those whom their parents wish to be examined. He also selects children for vacation camps and open-air schools, and advises parents on their children's health.

A tuberculin test is given to every child entering school. Children with a positive reaction are referred to the Tuberculosis Division of the Oslo Department of Health; those with a negative reaction are retested annually.

All children in Oslo are examined by an ear, nose, and throat specialist during their first year at school. An eye specialist examines those referred to him after inspection by a specially trained nurse. Also all boys are tested for color-blindness. An orthopedic surgeon and a psychiatrist examine the children when necessary.

The school physician does not treat the children but refers them to other physicians and, through school nurses, he tries to make sure that his advice is followed.

Every teacher is given an examination for tuberculosis, including an X-ray of the chest, at the time of entering the service and once a year thereafter.

The city of Oslo, population 275,000, has 20,000 children in the public schools, elementary, continuation, and secondary; it employs 30 general practitioners, one of whom is director of school health, 4 specialists, and 15 nurses. Some of the physicians are on part time.

Dental care

Dental care of school children was introduced in Norway in 1910, at first in Oslo, and later in other cities and in rural districts. Much of the early work was done with local public funds.

In 1917 the Norwegian Parliament began to make available grants to those local authorities that undertook to give free dental care to school children; but the results were considered inadequate. Therefore, the cities were directed by a law of 1936 to introduce free dental care in all elementary schools; in rural schools this was to be done whenever funds were provided by the local authorities. Government aid was made available for both city and rural schools.

Most of the urban communes, administrative divisions, have school dental clinics, but only about one-third of the rural communes had such clinics up to 1943.

Dental hygienists have been employed for over 20 years. Their training, as reported by the chief dental officer of the Oslo schools, is patterned on that in the United States.

One of the best systems of dental care in Norway is found in Oslo. Both preventive and complete corrective treatment are given, including extraction, filling, correction of irregular position of the teeth, treatment of diseases of the gums, minor oral surgery, and periodic X-rays. Although attendance at the school dental clinics is optional, 95 percent of Oslo's school children were examined there in the school year 1944–45. Of these, 91 percent were treated; the rest declined treatment. In that year 19 clinics were open every school day, staffed by 20 dentists—14 full time—and 8 full-time dental hygienists.

The city of Oslo also provides dental care for dependent children in institutions near Oslo and to children placed in foster homes in localities that have no free dental care for school children. The foster children are visited by mobile dental clinics. Also, children who attend schools maintained by churches or other organizations are regularly treated in the school dental clinics of Oslo.

Besides giving free dental treatment to school children, the city of Oslo has been since 1939 providing dental treatment at a nominal charge for children between the ages of 3 and 7 and for young people from 15 to 18 years. In this way all residents of Oslo between the ages of 3 and 18 years may obtain continuous dental care.

For persons over 18 free dental service has been available in Oslo since 1942. Every person in the city over 18, who is covered by sickness insurance and who has been under continuous dental supervision in a public or private clinic from the age of 3 until 18, is eligible for dental care without charge. This is of great importance, since sickness insurance is compulsory for two-thirds of the population.

Mental hygiene

At least two psychological clinics, one of them in Oslo, were operating in connection with the public schools in March 1947. Several other cities were planning at that time to open such clinics. They examine problem children and those considered for placement in a special class or school. Approval by a psychiatrist or psychologist is necessary for placing a child in such a class or school or in an institution for mentally defective, wayward, and other problem children.

Psychiatric nurses assist the psychiatrists.

School meals

School lunches were introduced in Norway about 50 years ago. Since 1925 they have been gradually replaced by the famous Oslo breakfasts, originated by Dr. Carl Schiötz, chief medical officer of the Oslo schools. The breakfast, with slight variations, is served free of charge to school children in many parts of the country, mostly in cities and towns. The breakfast is optional and is served, with the parents' consent, to all children, without distinction. In Oslo 90 percent of the school children receive the breakfast.

The breakfast consists of as much whole-rye or other whole-grain bread as the child wishes, with margarine and a kind of whey cheese; also either half an apple, or half an orange, or 2 ounces of raw carrot, alternating every third week; and about a pint of fresh milk. Carrots are used mostly in the fall because they are then cheaper and better. The breakfast is served every school day 45 minutes before class time. Children who eat the school breakfast are instructed to take no food before leaving home.

In Oslo the breakfast is prepared in the municipal central kitchen and brought to the schools. Serving of the breakfast is supervised by teachers who volunteer their services. The children are taught to eat slowly and to observe table manners.

The cost of the meals is met in most cases by the cities, in other instances by private organizations.

An educational campaign has been conducted among parents as to the value of the breakfasts.

Vacation camps and open-air schools

Large numbers of vacation camps for school-age children are maintained in Norway. These camps are for children, below par in health, who are from low-income families. The camps maintained by cities and some private organizations are free. The city of Oslo has maintained vacation camps for nearly 30 years. Early in 1947 the city had 32 such camps, with places for 2,500 to 2,700 children.

In the municipal camps the children are examined by a physician within 2 weeks after arrival and are kept under medical supervision during their stay, which is usually 6 weeks.

In recent years 92 percent of the school children in Oslo have been having vacations in the summer, for at least 3 weeks, at either free or paid camps.

Public and private open-air schools for children exposed to tuberculosis in their families and delicate children who are living under insanitary conditions function the year round in many parts of the country.

• FOR YOUR BOOKSHELF

UNDERSTANDING THE PSYCHOLOGY OF THE UNMARRIED MOTHER. Family Service Association of America, 122 East Twenty-second Street, New York 10. 1947. 32 pp. 50 cents.

Four papers, by Babette Block, Sylvia Oshlag, Frances H. Scherz, and Leontine R. Young, reprinted from *The Family*, now the *Journal of Social Casework*.

ADOPTING A CHILD, by Frances Lockridge, with the assistance of Sophie van S. Theis, Secretary of the Child Placing and Adoption Agency of the New York State Charities Aid Association. Greenberg: Publisher. New York, 1947. 216 pp. $3.

Written for adoptive parents, this book emphasizes the beneficial role of the authorized agency in adoption. It answers many questions of prospective adoptive parents—the steps in adoption, the information needed on adoptive parents and children to be adopted, where the children stay until they are adopted, the probationary period and its purpose. It also shows why there are children in institutions and foster homes who need to be cared for but are not available for adoption.

Psychological testing of infants is discussed briefly.

Comments on the relative importance of environment and heredity are quoted from the staff psychiatrist of the Child Placing and Adoption Committee.

Parental attitudes as a basis for a successful adoption are considered. In addition to the necessity for telling a child he is adopted, the problems connected with giving him knowledge of his background are mentioned.

Improving the parent-child relationship rather than granting abrogations of adoptions is stressed. One chapter is given over to summarizing some of the provisions in adoption laws of the various States.

I. Evelyn Smith

THE HOUSEMOTHER'S GUIDE, by Edith M. Stern in collaboration with Howard W. Hopkirk. Commonwealth Fund, New York, 1946. 91 pp. 1 to 9 copies, 50 cents each; 10 to 49 copies, 37½ cents each; 50 or more copies, 35 cents each.

Children need love, self-confidence, and the opportunity to develop initiative; they must be understood and treated as individuals with individual differences; meeting their needs, emotional as well as physical, is the most important part of the job; and their life in an institution must not only be satisfactory in itself but also prepare them for life in the world later. These are the principles that this pamphlet aims to help housemothers in institutions to carry out.

The pamphlet points out the fact that the essential part of the housemother's work is not so much to maintain orderliness and mannerliness and regularity of habits and obedience, as it is to provide understanding and affection. It emphasizes that housemothers should never expect thank-yous; that good mothers never demand gratitude, and neither should good mother-substitutes; and that to express appreciation is a part of adult, not of childish behavior.

Much of the material relating to handling problems of children outside their own homes and relationships to their parents would be helpful also to foster mothers.

I. Evelyn Smith

DELINQUENT GIRLS IN COURT; A study of the wayward-minor court of New York, by Paul W. Tappan. Columbia University Press, New York, 1947. 265 pp. $3.

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Our January cover picture shows a proud granddad and a radiant granddaughter, photographed by Clifford J. Hynning.

Credits for other photographs:

Page 99, left, Virginia State Health Department; right, E. S. Powell for South Carolina State Board of Health.

Pages 100 and 106, Federal Works Agency.

Page 102, Philip Bonn for U. S. Children's Bureau.

Page 104, New Mexico State Department of Public Health.

Page 105, Social Security Administration.

Page 107, Federal Public Housing Authority.

FOR OUR CHILDREN'S FUTURE

As a Nation we have much unfinished business to do for our children, as is pointed out by the thirty-fifth annual report of the Children's Bureau, outlined in part in this issue of *The Child*.

Despite the high level of medical care in this country, we are doctor-poor. Particularly is this true in rural areas. Only 4 percent of our pediatricians are in places of less than 10,000 population, where 60 percent of our children live.

What are we going to do to bring these rural children within reach of doctors, hospitals, diagnostic clinics?

Every State now has specialized health and welfare services for children, but no State has services sufficiently well staffed to serve all children needing help.

What are we going to do about the counties—two out of every five—that lack a full-time public-health unit?

What are we going to do about the one-third of our counties that have no public-health nurse; the three out of four rural counties with no regular maternity clinic; the two out of three rural counties with no regular monthly well-child conferences?

We have reduced the infant mortality rate for the Nation to 38 per 1,000 live births, but what are we going to do for the 21 States whose rate is above that figure?

For the Nation as a whole, we have reduced the maternal mortality rate to 21 for every 10,000 live births. But what about the 20 States which lose more mothers than that?

We know that one out of every three deaths in the United States is due to diseases of the heart and blood vessels, and that rheumatic fever, including rheumatic heart disease, causes much of the heart disease in later life.

The care of many children attacked by this disease is a public-health problem, because their care is expensive and long-drawn-out. Twenty-two States have programs for the care of children with rheumatic fever or rheumatic heart disease. What about the other States?

We have some 500,000 children with orthopedic defects—clubfoot, harelip, cleft palate, and other handicaps—which are sometimes serious emotional handicaps as well as physical ones. Some of these half-million children are being cared for under State crippled children's services. But every State knows of crippled children who are forced to go without care because the State is unable to supply it.

The list of physically blighted children goes on. Some 170,000 have cerebral palsy, and at least 70 percent of these could be educated and trained to live useful, satisfying lives. We have almost nothing to offer them in public programs, and yet the cost of the training and care they should have is beyond the reach of many of their parents.

Our schools, year after year, find children with defective hearing, with bad eyesight, with bad teeth. We send them home with notes, urging their parents to do something about Johnny's bad teeth and Mary's poor eyes, knowing full well that in most cases their parents, reading the notes, can only worry some more.

We are concerned about our juvenile delinquency, knowing that a child in serious difficulty with the law is an unhappy, maladjusted child needing special attention. We have child-welfare workers to help these and other children with special needs, such as children born out of wedlock, but we have only 2,200 such workers for the whole country.

We have much more to learn about the physical and emotional growth of children. Research and action must go hand in hand.

The question that faces us is simply this: How deeply do we care about moving ahead on these unsolved problems?

Oscar R. Ewing

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